wisconsin Medicaid update
and BadgerCare

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Wisconsin Medicaid and BadgerCare Information for Providers

To:

- HMOs and Other Managed Care Programs
- VIPs and Subscribers
- Physicians and Physician Clinics
- Physician Assistants
- Independent Laboratories
- Rural Health Clinics

Second Opinion Elective Surgery Request/ Physician Report Form revised

The Second Opinion Elective Surgery Request/ Physician Report Form published in the Medicine and Surgery section of the Physician Services Handbook is incorrect. The signature and date lines are missing. Please use the attached revised form for further requests.

The *Wisconsin Medicaid and BadgerCare Update* is the first source of program policy and billing information for providers.

Although the *Update* refers to Medicaid recipients, all information applies to BadgerCare recipients also.

Wisconsin Medicaid and BadgerCare are administered by the Division of Health Care Financing, Wisconsin Department of Health and Family Services, P.O. Box 309, Madison, WI 53701-0309.

For questions, call Provider Services at (800) 947-9627 or (608) 221-9883 or visit our Web site at *www.dhfs.state.wi.us/medicaid/*.

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Appendix 27
Second Opinion Elective Surgery Request/Physician Report Form

(for photocopying)

Recommending Surgeon Information

Date: _____ Note: The recommending surgeon must complete this side of the form before sending to the second opinion physician.

Check One: ☐ Would like the second opinion physician to send this form back to me.
☐ Would like the second opinion physician to send this form directly to the Medicaid fiscal agent.

Recipient (Patient) Information:

Name: _____ Medicaid ID Number: _____

Address: _____ County: _____

_____ Telephone: _____

_____ Date of Birth: _____/_____/_____ Sex: _____

Recommending Surgeon (mailing address):

Name: _____ Provider Number: _____

Address: _____ Telephone: _____

_____

_____

If someone other than the recipient (parent, relative, guardian, etc.) should be contacted concerning the second opinion, please specify:

Person to Contact: _____ Telephone: _____

Address: _____

_____

_____

Primary/Referring Physician (if different from above):

Name: _____ Address: _____

Check Proposed Procedure:

_____ Cataract extraction and/or intraocular lens implant (check if bilateral___): 66840, 66850, 66852, 66920, 66983, 66984

_____ D & C (diagnostic): 58120

_____ Hernia repair (inguinal, age 5 or older) (check if bilateral___): 49505, 49520, 59525, 56316, 56317

_____ Joint replacement – Hip (check if bilateral___): 27130, 27132

_____ Tonsillectomy and/or Adenoidectomy: 42820, 42821, 42825, 42826, 42830, 42831, 42835, 42836

_____ Cholecystectomy: 47600, 47605, 47610, 56340, 56341, 56342

_____ Hemorrhoidectomy: 46250, 46255, 46257, 46258, 46260, 46261, 46262

_____ Hysterectomy: 56308, 58150, 58152, 58180, 58260, 58262, 58263, 58267, 58270, 58275, 58280

_____ Joint replacement – Knee (check if bilateral ____): 27446, 27447

_____ Varicose Vein Surgery: 37700, 37720, 37730, 37735, 37780, 37785

Second Opinion Physician Information

Note: The physician performing the second opinion must complete this side of the form.

Physician Name: _____

Address: _____

_____

Telephone: _____

Medicaid Provider Number: _____

Findings (include any information on alternative treatment, additional medical tests, or other significant findings):

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Check One: ☐ I agree with the need for the surgery.
☐ I do not agree with the need for the surgery.

Comments: _____

_____

_____

Physician's Signature: _____ Date: _____

Following the recommending surgeon's request indicated on the front page, return this form to one of the following:

- Alternative #1: *Return to Recommending Surgeon* (Name and address listed on front page)
- Alternative #2: *Mail to:* SSO Department
  Medicaid Fiscal Agent
  6406 Bridge Road
  Madison, WI 53784-0012